

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005019</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>11/19/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GIBSON GENERAL HOSPITAL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1808 SHERMAN DR PRINCETON, IN 47670</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>JCAHO Surveyor: 34586 Facility Number: 005019</p> <p>Type of Survey: State Licensure Off Site JCAHO Accreditation Survey</p> <p>Date of JCAHO On Site Survey - Hospital full survey NOV. 18-19/2014</p> <p>Date of ISDH off site review - June 8, 2015 Reviewer/Surveyor -Kerry Sawin, RN, PHNS</p> <p>Based on review of the Nov. 18-19/ 2014 JCAHO Accreditation Survey Report, it has been determined that Gibson General Hospital meets the requirements for Hospital Licensure in Indiana for 2014.</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE